2017 Health and Life Insurance
PARTICIPATING AGENCIES – Election Form

PRIMARY INFORMATION – Please PRINT

Use this form for initial insurance enrollment or for an eligible qualifying event. **Additional paperwork may be required** (see the Required Documentation and Dependent Eligibility document) and return to the Health Insurance Team by the applicable deadline.

SSN: _____ – _____ – _____

Name: _____

Street Address: _____

City, State, ZIP Code: _____

Telephone Home #: (_____) _____ – _____ Cell #: (_____) _____ – _____

Email Address: _____

*Your email address will not be shared and will **only be used by OHR** to contact you regarding your health insurance.*

Medical (choose one)

- ❑ No Medical coverage
- ❑ Kaiser HMO (includes Kaiser Rx)
- ❑ United HealthCare HMO
- ❑ CareFirst POS High Option
- ❑ CareFirst POS Standard Option

Dental (choose one)

- ❑ No Dental coverage (2-year waiting period to re-enroll)
- ❑ Dental PPO (traditional dental plan)
- ❑ Dental DHMO

Vision Plan (choose one)

- ❑ No Vision Coverage (2-year waiting period to re-enroll)
- ❑ Vision Plan

Prescription / Rx (choose one)

For the Kaiser medical plan, no Rx election is needed.

- ❑ No Prescription coverage
- ❑ High Option Rx plan
- ❑ Standard Option Rx plan

Optional Life (choose one)

To increase coverage, a Statement of Health may be required.

- ❑ No Optional Life coverage
- ❑ 1x annual earnings
- ❑ 2x annual earnings
- ❑ 3x annual earnings
- ❑ 4x annual earnings
- ❑ 5x annual earnings
- ❑ 6x annual earnings
- ❑ 7x annual earnings
- ❑ 8x annual earnings

Dependent Life (choose one)

- ❑ No Dependent Life coverage
- ❑ $2,000 / $1,000
- ❑ $4,000 / $2,000
- ❑ $10,000 / $5,000

Over ↺

DEPENDENT COVERAGE – Please PRINT

To change dependent coverage, complete the section below and **include copies of the required documentation** (e.g., birth certificate, adoption certificate, marriage certificate, etc.). Note that you must elect the same coverage for yourself in the medical, prescription, dental and/or vision sections of this form (e.g., your dependent may not have the vision plan unless you do).

❑ **Add Eligible Dependent(s)** ❑ **Keep Same Dependent Coverage**

SOCIAL SECURITY NUMBER *(Required)*	FULL NAME OF ELIGIBLE DEPENDENT	DATE OF BIRTH	GENDER	RELATIONSHIP	INSURANCE ELECTIONS
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision

❑ **Delete / Disenroll Dependent(s)**

FULL NAME OF DEPENDENT	NO LONGER ELIGIBLE	COVERAGE TO BE CANCELLED
	❑	❑ Medical ❑ Dental ❑ Rx ❑ Vision
	❑	❑ Medical ❑ Dental ❑ Rx ❑ Vision

SIGNATURE (must be signed to be effective)

I have read the materials available for the County's Group Insurance Program (Program). If my employer utilizes the County's payroll system, I authorize the County to make a payroll deduction for my benefit elections and understand that the County may adjust my elections. If I pay directly for benefits insurance, I will promptly pay the cost or benefits will terminate. I understand that I can only change my elections during the year if I have a status change (see Summary Description). I authorize the release of enrollment information to entities such as benefit carriers to the extent necessary to properly administer my elections. I understand that electing benefits to which I or any other person is not entitled is considered fraud and if I misrepresent my eligibility or that of any other person, or fail to take the steps necessary to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, benefits will terminate. In addition, I must repay any claims which have been paid inappropriately, and I may face charges. I understand that the County expects to continue the Program, but it is the County's position that there is no implied contract between employees and the County to do so. I also understand that the County reserves the right at any time and for any reason to amend the Program, subject to the County's collective bargaining agreements. The County may also amend the Program, prospectively or retroactively to comply with applicable law.

⇨ **Signature:** _____ **Date:** _____

IMPORTANT: All documents MUST be signed and returned to the OHR Health Insurance Team within 60 days for a qualified status change event.

Mail to: OHR Health Insurance Team, 101 Monroe St., 7th Floor, Rockville, MD 20850
or fax to: 240-777-5131 (include fax/mail cover sheet).

10/24/2016